DOCUMENT RESUME

ED 233 551 EC 160 079

AUTHOR Deutsch, Henri; Placona, Michael
TITLE Psychotherapeutic Approaches to Dealing with Mentally Retarded Adolescents and Adults in Community Settings.
PUB DATE [83]
NOTE 19p.
PUB TYPE Reports - Research/Technical (143)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Health Services; *Mental Health

ABSTRACT

Fifty-one professionals from fields of education, psychology, nursing, counseling, social work, and direct care completed a questionnaire intended to examine therapeutic approaches used with mentally retarded persons who are also emotionally disturbed. Questionnaires were accompanied by case studies of three mildly retarded young men. Treatments chosen with the greatest frequency were individual and family therapy, behavior modification, and group therapy. Out of a possible 306 treatment options, the choices of behavior modification and psychotherapy were selected 194 times. Selection of either approach was dependent on the type of case presented, suggesting that the decision may reflect basic social values and norms about the needs of certain types of clients. Neither degree or education appeared to affect treatment choice. When all cases were combined, psychotherapy was chosen more frequently than behavior modification. The two treatments were largely judged to be mutually exclusive, a view that may be an outgrowth of the history of behavior modification. (CL)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)
☑ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.
• Points of view or opinions stated in this document do not necessarily represent official NIE position or policy.

ED233551

PSYCHOTHERAPEUTIC APPROACHES TO DEALING WITH MENTALLY RETARDED ADOLESCENTS AND ADULTS IN COMMUNITY SETTINGS

++

HENRI DEUTSCH, PH.D.
DIRECTOR OF CLINICAL SERVICES
KEYSTONE CITY RESIDENCE
406 N. WASHINGTON AVENUE
SCRANTON, PA. 18503

AND

MICHAEL PLACONA, M.A.
RESEARCH DIRECTOR
LACKAWANNA/SUSQUEHANNA/WAYNE COUNTY
MENTAL HEALTH/MENTAL RETARDATION PROGRAM
SCRANTON, PA. L8503

FC 160079

+
"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
Henri Deutsch
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

ALTHOUGH THE INCIDENCE OF EMOTIONAL DISTURBANCE AMONG THE MENTALLY RETARDED IS GREATER THAN THAT OF THE GENERAL POPULATION, MENTAL HEALTH SERVICES FOR THESE INDIVIDUALS HAS BEEN LACKING. TRADITIONALLY, THOSE PEOPLE WHO WERE MENTALLY RETARDED AND EMOTIONALLY DISTURBED WERE INSTITUTIONALIZED, THUS NEGATING THE PRESSUURE TO PROVIDE MENTAL HEALTH SERVICES IN THE COMMUNITY. AS THE DEINSTITUTIONALIZATION PROCESS CONTINUES, THESE EMOTIONALLY DISTURBED/MENTALLY RETARDED INDIVIDUALS WILL BE RESIDING IN COMMUNITY ALTERNATIVES, AND WILL REQUIRE COMPETENT MENTAL HEALTH SERVICES. HOWEVER, THE FORM THAT THESE SERVICES TAKE MAY VARY CONSIDERABLY BETWEEN SETTINGS AND BETWEEN PRACTITIONERS.

THERE APPEARS TO BE A SPLIT BETWEEN THE FIELDS OF MENTAL HEALTH AND MENTAL RETARDATION. IT IS BELIEVED THAT THE MENTAL HEALTH PRACTITIONERS ARE RELUCTANT TO SEE THE MENTALLY RETARDED, AND MENTAL RETARDATION WORKERS ARE HESITANT TO DEAL WITH PROBLEMS OF EMOTIONAL DISTURBANCE. WHETHER THESE THERAPEUTIC BIASES ACTUALLY EXIST WAS RESEARCHED USING A QUESTIONAIRE FORMAT. THE RESEARCH QUESTIONS INCLUDED THE FOLLOWING:

1) WHAT ARE THE CHARACTERISTICS OF THE PROBLEMS OF THE MENTALLY RETARDED TO WHICH CLINICIANS RESPOND?

2) HOW DOES A CLINICAN ORGANIZE HIS/HER THERAPEUTIC INTERVENTION? WHAT THERAPEUTIC MODALITIES ARE UTILIZED?

3) WHAT IS THE DEGREE OF COMFORT THAT CLINICIANS EXPERIENCE IN WORKING WITH THE EMOTIONALLY DISTURBED/MENTALLY RETARDED?

4) DO CLINICIANS WITH DIFFERENT BACKGROUNDS VIEW THE PROBLEMS DIFFERENTLY OR EXPERIENCE DIFFERENT DEGRESS OF COMFORT?

METHOD:

A QUESTIONAIRE WAS DEVELOPED TO ASSESS CLINICIANS RESPONSES TO ISSUES CONCERNING THERAPEUTIC APPROACHES WITH THE MENTALLY RETARDED/EMOTIONALLY DISTURBED. THE QUESTIONAIRE WAS REVIEWED BY A PANEL OF FOUR EXPERTS IN THE FIELDS OF MENTAL RETARDATION AND MENTAL HEALTH TO DETERMINE CONTENT VALIDITY.

THE QUESTIONAIRE CONSISTED OF SEVERAL SECTIONS:

PART I. DEGREE OF COMFORT IN DOING PSYCHO-THERAPY/COUNSELING WITH A VARIETY OF PSYCHIATRIC DISORDERS.

PART II. PERCEIVED BENEFIT OF PSYCHO/THERAPY COUNSELING WITH THE SAME GROUP OF PSYCHIATRIC DISORDERS.

PART III. THREE CASE STUDIES:

A) IDENTIFICATION OF MAJOR PROBLEM AREAS.

B) INTERVENTION PRIORITIES.

PART IV. RESPONDENT INFORMATION.

THE CASE STUDIES DESCRIBED THREE MILDLY RETARDED YOUNG MEN WHO LIVED IN GROUP HOMES AND WHO WERE EAGER TO LIVE WITH THEIR PARENTS. THE CASES DIFFERED IN THE MANNER IN WHICH THESE FEELINGS WERE DISPLAYED.

CASE I: PSYCHOLOGICAL ISOLATION AND FANTASY

CASE II: PSYCHOLOGICAL ISOLATION AND ACTING OUT

CASE III. PSYCHOLOGICAL ISOLATION, ACTING OUT AND FANTASY

FIFTY-ONE (51) RESPONDENTS FROM A VARIETY OF DISCIPLINES (PSYCHOLOGY, EDUCATION, NURSING, COUNSELING, SOCIAL WORK AND DIRECT CARE) COMPLETED THE QUESTIONAIRE. THESE PROFESSIONALS HAD VARIOUS DEGREES OF EXPERTISE WITH THE MENTALLY RETARDED AND WORKED IN RESIDENTIAL, SCHOOL, MENTAL HEALTH AND COMMUNITY SETTINGS.

AS THIS WAS A PRELIMINARY STUDY, NOT ALL OF THE DATA WAS ANALYZED. THIS PAPER WILL REPORT ON PREFERRED TREATMENT MODALITIES AS A FUNCTION OF EDUCATION,

COURSES IN MENTAL RETARDATION, DISCIPLINE, AND THE NUMBER OF EMOTIONALLY DISTURBED/MENTALLY RETARDED CLIENTS ON ONE'S CASELOAD.

RESULTS:

THE FOLLOWING TABLE PRESENTS THE FREQUENCIES OF TREATMENT CHOSEN BY THE RESPONDENTS FOR CASE I:

TABLE I

MODALITY	E	%
CHEMOTHERAPY	1	1
BEHAVIOR MODIFICATION	14	14*
GUIDANCE	7	7*
SOCIALIZATION TRAINING	8	8*
VOCATIONAL TRAINING	2	2
INDIVIDUAL THERAPY	25	26*
GROUP THERAPY	13	13*
FAMILY THERAPY	21	22*
RESIDENTIAL	6	6*

* PROBABILITY THAT ($P \leq \%\ I \pm 1001\ E\ P = .01$) IS .95 OR MORE.

A VARIETY OF THERAPEUTIC ALTERNATIVES WERE PROVIDED FOR EACH CASE STUDY. THE PREDOMINANT FACTORS IN EACH CASE WERE "BEHAVIOR MODIFICATION" AND "PSYCHOTHERAPY". INDIVIDUAL, GROUP AND FAMILY THERAPY CATEGORIES WERE COLLAPSED INTO ONE GROUP LABELED PSYCHOTHERAPY. SEVERAL OTHER CATEGORIES (SOCIALIZATION TRAINING, RESIDENTIAL) DID NOT OCCUR CONSISTENTLY ENOUGH TO BE INCLUDED IN THE ANALYSIS.

TABLE II DISPLAYS THE BREAKDOWN OF RESPONDENTS BY DISCIPLINE, AND THE RELATIVE FREQUENCY OF CHOICES BETWEEN BEHAVIOR MODIFICATION AND PSYCHOTHERAPY FOR EACH DISCIPLINE. WHEN THE THREE CASES ARE COLLAPSED, THE FREQUENCY DISTRIBUTIONS WERE ALMOST IDENTICAL. HOWEVER, WHEN THE TREATMENT PREFERENCES WERE COMPARED BY CASES, (TABLE III) MARKED DIFFERENCES OF TREATMENT CHOICES OCCURRED BETWEEN CASES. PSYCHOTHERAPY WAS TREATMENT OF CHOICE IN CASE I WHERE THE INDIVIDUAL DID

TABLE II FIRST CHOICE OF THERAPEUTIC INTERVENTION BY DISCIPLINE FOR ALL THREE CASES.

		Behavior Modification	Psychotherapy (Individual, Group & Family
Psychologist	16	19	16
Social Worker	6	4	5
Educator	6	4	7
Nurse	2	1	0
Counselor	5	4	5
Direct Care	6	6	5
Other	9	7	12
Totals:		45	49

NOT DISPLAY ACTING OUT BEHAVIOR, WHILE BEHAVIOR MODIFICATION WAS A PREDOMINANT CHOICE IN CASE III WHERE ACTING OUT BEHAVIORS WERE DESCRIBED.

THE FOLLOWING TABLE SHOWS THE FREQUENCY OF CHOICE FOR BEHAVIOR MODIFICATION AND PSYCHOTHERAPY AMONG RESPONDENTS TO EACH OF THE THREE CLINICAL CASES THAT WERE PRESENTED IN THE SURVEY. RESPONDENTS WERE ASKED TO IDENTIFY TWO TREATMENT MODALITIES AS THEIR FIRST AND SECOND TREATMENTS OF CHOICE.

TABLE III PREFERENCE FOR BEHAVIORAL MODIFICATION AND PSYCHOTHERAPY

	CASE 1	CASE 2	CASE 3	TOTAL
BEHAVIOR MODFICATION	14	26	35	75
PSYCHOTHERAPY	59	39	21	119
TOTAL:	73	65	56	194

OUT OF A POSSIBLE 306 TREATMENT OPTIONS, THE CHOICES OF BEHAVIOR MODIFICATION AND PSYCHOTHERAPY WERE SELECTED 194 TIMES. THE FREQUENCY REPRESENTS 63% OF THE POSSIBLE OPTIONS AVAILABLE. A BINOMIAL ANALYSIS SHOWS THAT THE OBSERVED PROPORTION OF .63 IS SIGNIFICANT WHEN THE EXPECTED PROPORTION OF THE SAMPLE RANDOMLY RESPONDING IS ESTIMATED AT .01. ($P \leq .63$; $P > .99$). IT SHOULD ALSO BE NOTED THAT THE DISTRIBUTION OF PREFERENCE FOR BEHAVIOR MODIFICATION OR PSYCHOTHERAPY AS OPPOSED TO OTHER MODALITIES IS RANDOMLY DISTRIBUTED ACROSS THE THREE CASES. THE CASES DID NOT HAVE A SIGNIFICANT EFFECT ON THE PREFERENCE FOR BEHAVIOR MODIFICATION OR PSYCHOTHERAPY AS TREATMENTS OF CHOICE.

THE CHOICE BETWEEN PSYCHOTHERAPY AND BEHAVIOR MODIFICATION WAS, HOWEVER, AFFECTED SIGNIFICANTLY BY THE CASES. ALTHOUGH RESPONDENTS WERE FREE TO IDENTIFY BOTH BEHAVIOR MODIFICATION AND PSYCHOTHERAPY AS TREATMENTS OF CHOICE FOR EACH OF THE CASES, THEIR PREFERENCE FOR EACH MODALITY WAS DEPENDENT ON THE TYPE OF CASE PRESENTED. BEHAVIOR MODIFICATION WAS SELECTED MOST OFTEN WHILE PSYCHOTHERAPY WAS LEAST PREFERRED WHEN PSYCHOLOGICAL ISOLATION, FANTASY, AND ACTING OUT WERE ALL PRESENT (CASE III), IN CONTRAST, PSYCHOTHERAPY WAS SELECTED

TABLE IV FIRST CHOICE OF THERAPEUTIC INTERVENTION AS RELATED TO EDUCATION FOR CASE I (ISOLATION AND FANTASY)

INTERVENTION	BA OR LESS (N=19)	GRADUATE DEGREE (N=30)
BEHAVIOR MODIFICATION	16%	13%
PSYCHOTHERAPY (INDIVIDUAL GROUP AND FAMILY)	58%	53%
CHEMOTHERAPY	5%	0

TABLE V FIRST CHOICE OF THERAPEUTIC INTERVENTION AS RELATED TO EDUCATION FOR CASE III (PSYCHOLOGICAL ISOLATION, FANTASY AND ACTING OUT)

INTERVENTION	BA OR LESS (N=19)	GRADUATE DEGRESS (N=30)
BEHAVIOR MODIFICATION	37%	36%
PSYCHOTHERAPY (INDIVIDUAL, GROUP AND FAMILY)	42%	23%
CHEMOTHERAPY	5%	0

TABLE VI FIRST CHOICE OF THERAPEUTIC INTERVENTION AS RELATED TO EDUCATION FOR CASE III (PSYCHOLOGICAL, ISOLATION FANTASY AND ACTING OUT)

INTERVENTION	BA OR LESS (N=19)	GRADUATE DEGREE (N=30)
BEHAVIOR MODIFICATION	37%	50%
PSYCHOTHERAPY (INDIVIDUAL, GROUP AND FAMILY)	16%	17%
CHEMOTHERAPY	16%	13%

TABLE VII FIRST CHOICE OF THERAPEUTIC INTERVENTION AS RELATED TO COURSES IN MENTAL RETARDATION FOR CASE I

(PSYCHOLOGICAL ISOLATION AND FANTASY)

INTERVENTION	FEW COURSES (N-27)	MANY COURSES (N-22)	% OF TOTAL SAMPLE
BEHAVIOR MODIFICATION	7% OF RESPONDENTS	23% OF RESPONDENTS	14
PSYCHOTHERAPY (INDIVIDUAL GROUP AND FAMILY)	63% OF RESPONDENTS	45% OF RESPONDENTS	55
CHEMOTHERAPY	4% OF RESPONDENTS	NO RESPONSES	02

TABLE VIII FIRST CHOICE OF THERAPEUTIC INTERVENTION AS RELATED TO COURSES IN MENTAL RETARDATION FOR CASE II

(PSYCHOLOGICAL ISOLATION AND ACTING OUT)

INTERVENTION	FEW COURSES (N-27)	MANY COURSES (N-22)	% OF TOTAL SAMPLE
BEHAVIOR MODIFICATION	26% OF RESPONDENTS	50% OF RESPONDENTS	36
PSYCHOTHERAPY (INDIVIDUAL GROUP AND FAMILY)	37% OF RESPONDENTS	23% OF RESPONDENTS	31
CHEMOTHERAPY	4% OF RESPONDENTS	NO RESPONSES	02

TABLE IX FIRST CHOICE OF THERAPEUTIC INTERVENTION AS RELATED TO COURSES IN MENTAL RETARDATION FOR CASE III

(PSYCHOLOGICAL ISOLATION, FANTASY AND ACTING OUT)

INTERVENTION	FEW COURSES (N-27)	MANY COURSES (N-22)	% OF TOTAL SAMPLE
BEHAVIOR MODIFICATION	44%	45%	45
PSYCHOTHERAPY (INDIVIDUAL GROUP AND FAMILY)	11%	23%	16
CHEMOTHERAPY	19%	10%	14

MOST OFTEN WHILE BEHAVIOR MODIFICATION WAS LEAST PREFERRED WHEN ONLY PSYCHOLOGICAL ISOLATION AND FANTASY WERE PRESENT. BOTH PSYCHOTHERAPY AND BEHAVIOR MODIFICATION WERE PROPORTIONATELY SELECTED WHEN ONLY ACTING OUT WAS PRESENT IN A CASE ($\chi^2 = 25.2$; $P > .99$)

THIS FINDING SHOWS THAT RESPONDENTS TENDED TO HOLD AN IMPLICIT DECISION RULE ABOUT PREFERRED TREATMENT THAT IS CONTINGENT UPON BEHAVIORAL ASPECTS OF A CASE. THE SELECTION OF PSYCHOTHERAPY OR BEHAVIOR MODIFICATION APPEARS, THEREFORE, TO REFLECT BASIC SOCIAL VALUES AND NORMS ABOUT THE NEEDS OF CERTAIN TYPES OF CLIENTS. ONE MIGHT HYPOTHESIZE THAT RESPONDENTS FELT DIFFERENTLY ABOUT THE NATURE OF A PROBLEM BASED LARGELY ON WHETHER ACTING OUT OR PSYCHOLOGICAL FANTASY AND ISOLATION WERE PRESENT IN A CASE.

TABLES IV TO VI SHOW THE RELATIONSHIP BETWEEN THERAPEUTIC CHOICE AND EDUCATION WHILE TABLES VII TO IX COMPARE COURSES IN MENTAL RETARDATION WITH THERAPEUTIC CHOICE. THERE WERE NO SIGNIFICANT DIFFERENCES BETWEEN LEVELS OF EDUCATION AND THERAPEUTIC CHOICE NOR WERE THERE SIGNIFICANT DIFFERENCES BETWEEN THE NUMBER OF COURSES IN MENTAL RETARDATION AND THERAPEUTIC CHOICE. HOWEVER, IF THE DATA IS INSPECTED ON A CASE BY CASE BASIS, THERE ARE SEVERAL REMARKABLE CHANGES ACROSS THE TREATMENT OF CHOICE. THIS WOULD SUGGEST THAT ONE'S IDENTIFICATION OF A PROBLEM BEHAVIOR AND AN APPROPRIATE INTERVENTION IS NOT DEPENDENT ON EDUCATION OR DEGREE, BUT IS RATHER A FUNCTION OF THE BEHAVIORAL CHARACTERISTICS OF THE CASE ITSELF. THUS, BACHELOR'S LEVEL WORKERS WERE RESPONDING TO THE CASES IN A SIMILAR FASHION TO THOSE HOLDING DOCTORATES. IN ADDITION, THERE WAS A DRAMATIC UPSURGE IN THE PREFERENCE FOR CHEMOTHERAPY FOR CASE III. AS A PREFERRED TREATMENT, CHEMOTHERAPY WAS INSIGNIFICANT IN THE FIRST TWO CASES TO BEING EQUAL IN CHOICE TO PSYCHOTHERAPY IN THE THIRD CASE.

BEHAVIOR MODIFICATION AND PSYCHOTHERAPY ALSO CHANGE DRAMATICALLY ACROSS THE CASES. AS THE CASE DESCRIPTION INCLUDES MORE ACTING OUT BEHAVIORS AND FANTASY, THERE IS AN INCREASED TENDENCY TO CHOOSE BEHAVIOR MODIFICATION. ALSO,

WHEN THE FIRST AND SECOND CHOICES OF TREATMENT ARE COMPARED ACROSS CASES, ONE DISCOVERS THAT BEHAVIOR MODIFICATION AND PSYCHOTHERAPY TEND TO BE MUTUALLY EXCLUSIVE. THUS, AS ONE USES EITHER BEHAVIOR MODIFICATION OR PSYCHOTHERAPY, THERE IS A TENDENCY NOT TO USE THE OTHER APPROACH AS A SUPPORT TECHNIQUE.

TABLE X CONTRASTS THE PROPORTIONS OF A TREATMENT CHOICE FOR EACH CASE WITH THE AVERAGE PROPORTION OBTAINED FROM COMBINING THE PROPORTIONS OF THE THREE CASES TOGETHER.

TABLE X: CONTRAST BETWEEN CARE TREATMENT CHOICE PROPORTIONS AND AVERAGE PROPORTION OF A TREATMENT CHOICE FOR CASES COMBINED.

TREATMENT CHOICE	AVERAGE PROPORTION	CASE 1 PROP.	CASE 2 PROP.	CASE 3 PROP.	AVE PROPORTION VS P1	P2	P3
CHEMOTHERAPY	.04	.01	.01	.11	-.03	-.03	.07 *
BEHAVIOR MODIFICATION	.27	.14	.28	.41	-.11*	.01	.10*
GUIDANCE	.03	.07	.01	.01	.04*	-.02	-.02
SOCIAL IN.	.14	.08	.21	.12	-.06*	.07*	-.02
VOCATIONAL	.02	.02	.01	.02	.00	.01	.00
IND. THERAPY	.20	.26	.19	.15	.06*	-.01	-.05
GROUP THERAPY	.11	.13	.13	.08	.02	.02	-.03
FAMILY THERAPY	.16	.22	.22	.04	.06	.05	-.12*
RESIDENTIAL	.06	.06	.06	.06	.00	.00	.00

* $P(-1.64 \geq Z(P) \geq 1.64) = .05$

THE TABLE SHOWS WHEN CASE TREATMENT CHOICE PROPORTIONS ARE CONTRASTED USING AN ANALYSIS OF STANDARD NORMAL DEVIATES WITH THE AVERAGE TREATMENT CHOICE PROPORTION THAT A PATTERN OF PREFERENCE EXISTS AMONG RESPONDENTS. RESPONDENTS FAVORED SIGNIFICANTLY MORE THAN THEIR AVERAGE EXPECTATION THE MODALITIES OF GUIDANCE AND INDIVIDUAL THERAPY FOR CASE I WHILE DISFAVORING SIGNIFICANTLY BEHAVIOR

MODIFICATION. FOR CASE 2, ONLY SOCIAL TRAINING WAS SELECTED SIGNIFICANTLY MORE THAN THE AVERAGE EXPECTATION BY RESPONDENT WHILE ALL OTHER CHOICES TENDED TO BE LARGELY CONSISTENT WITH THE AVERAGE EXPECTATION FOR THE MODALITIES. FOR CASE 3, RESPONDENTS DISPROPORTIONATELY FAVORED CHEMOTHERAPY AND BEHAVIOR MODIFICATION WHILE THEY DISFAVORED BEYOND THEIR AVERAGE EXPECTATION FAMILY THERAPY.

TABLE XI

COMPARISON OF COMFORT IN WORKING WITH MILD-MODERATE EMOTIONALLY DISTURBED MENTALLY RETARDED CLIENTS AND TREATMENT OF CHOICE FOR ALL CASES.

	CHEMO-THERAPY	BEHAVIOR MODIFICATION	PSYCHOTHERAPY
HIGHLY COMFORTABLE	0	0	0
SOMEWHAT COMFORTABLE	1%	9%	13%
UNSURE	2%	20%	30%
SOMEWHAT UNCOMFORTABLE	3%	5%	8%
HIGHLY UNCOMFORTABLE	0	2%	7%
TOTALS:	6%	36%	58%

TABLE XI DEMONSTRATES THAT PSYCHOTHERAPY WAS THE PREDOMINATE CHOICE OF THERAPEUTIC INTERVENTION WITH THE MILD-MODERATELY MENTALLY RETARDED WITH EMOTIONAL DIFFICULTIES. THERAPIST'S CHOSE PSYCHOTHERAPY EVEN WHEN THEY INDICATED THAT THEY WERE UNCERTAIN OR UNCOMFORTABLE IN WORKING WITH THE MENTALLY RETARDED. THIS IS DEMONSTRATED DRAMATICALLY IN TABLE XII WHERE 78% OF THE RESPONDENTS STATED THAT THEY WERE UNCERTAIN OR UNCOMFORTABLE IN DOING PSYCHOTHERAPY WITH THE MILD-MODERATE EMOTIONALLY DISTURBED MENTALLY RETARDED INDIVIDUAL. THIS WOULD SUGGEST THAT ALTHOUGH A LARGE PROPORTION OF THERAPISTS ARE COMFORTABLE WITH PSYCHOTHERAPY AND STATE THAT IT IS A TREATMENT OF CHOICE EVEN FOR THE MILDLY RETARDED, IT IS UNLIKELY THAT THEY WOULD UTILIZE THIS TECHNIQUE WITH THIS GROUP.

TABLE XII

	EMOTIONALLY DISTURBED BUT NOT RETARDED	MILD-MODERATE, EMOTIONALLY DISTURBED & RETARDED	SEVERE-PROFOUND EMOTIONALLY DISTURBED & RETARDED
HIGHLY COMFORTABLE	4%	0	0
SOMEWHAT COMFORTABLE	39%	22%	16%
UNCERTAIN	43%	54%	33%
SOMEWHAT UNCOMFORTABLE	6%	18%	18%
HIGHLY UNCOMFORTABLE	8%	6%	33%

EVEN FOR THE MILDLY RETARDED, IT IS UNLIKELY THAT THEY WOULD UTILIZE THIS TECHNIQUE WITH THIS GROUP.

DISCUSSION:

TRADITIONALLY, BEHAVIOR MODIFICATION WAS VIEWED AS THE FOREMOST THERAPEUTIC MODALITY FOR WORKING WITH THE MENTALLY RETARDED. THIS STUDY SUGGESTS THAT PSYCHOTHERAPY IS ALSO CONSIDERED AN EFFECTIVE INTERVENTION FOR MANY EMOTIONALLY DISTURBED/MENTALLY RETARDED CITIZENS. IN FACT, WHEN ALL CASES ARE COMBINED, PSYCHOTHERAPY IS CHOSEN MORE FREQUENTLY THAN BEHAVIOR MODIFICATION. THIS STUDY ALSO SUGGESTS THAT MANY PRACTITIONERS VIEW PSYCHOTHERAPY AND BEHAVIOR MODIFICATION AS MUTUALLY EXCLUSIVE ESPECIALLY WHEN CONTRASTING AN INDIVIDUAL WHO IS ISOLATED AND USES FANTASY WITH ONE WHO IS ISOLATED, ACTING OUT AND FANTASIZING (CASE I AND CASE III). THIS SEPARATION OF THERAPEUTIC APPROACHES MAY BE BASED ON THE LOGICAL PRESUPPOSITION THAT BEFORE ONE CAN DEVELOP A RELATIONSHIP (WHICH IS THE BASIS FOR PSYCHOTHERAPY), ONE MUST BE IN CONTROL AND THAT THIS CONTROL MAY BE ACHIEVED THROUGH BEHAVIOR MODIFICATION OR CHEMOTHERAPY. ONCE THIS CONTROL IS ESTABLISHED, THERAPEUTIC RAPPORT CAN BE DEVELOPED AND PSYCHOTHERAPY MAY PROCEED.

ANOTHER POSSIBLE INTERPRETATION IS THAT PERSONAL INVOLVEMENT (PSYCHOTHERAPY) MAY DECREASE AS BEHAVIOR PROBLEMS INCREASE AS A DEFENSE MECHANISM ON THE PART OF THE THERAPIST. PSYCHOTHERAPY REQUIRES AN EMOTIONAL INVOLVEMENT ON THE PART OF THE THERAPIST, AS WELL AS THE CLIENT. THE THERAPIST MAY BE HESITANT TO RISK THAT INVOLVEMENT WHEN THE CLIENT IS ACTING OUT, AND MAY ATTEMPT TO ESTABLISH AN "EMOTIONAL" DISTANCE BETWEEN HIM/HERSELF AND THE CLIENT. THUS, AS THE THERAPEUTIC CLIMATE MOVES FROM TRUST AND PERSONAL INVOLVEMENT (PSYCHOTHERAPY) TO CONTROL (BEHAVIOR

MODIFICATION AND CHEMOTHERAPY), EMOTIONALY AS WELL AS COGNITIVE FACTORS MAY COME INTO PLAY IN THE THERAPIST'S DECISION.

THE PATTERN OF TREATMENT CHOICE OBSERVED IN THIS STUDY HAS THE IMMEDIATE EFFECT OF CREATING CONSIDERABLE SOCIAL DISTANCE BETWEEN CERTAIN CLIENTS AND THERAPISTS. ANXIETY PROVOKING CLIENTS ARE ASSIGNED TO TREATMENT MODALITIES THAT SERVE TO LIMIT THEIR PERSONAL CONTACTS WITH THERAPISTS. WITHOUT ADEQUATE OUTLETS TO EXPRESS THEIR FEELINGS AND CONCERNS, THE SUBJECTIVE MEANINGS OF ANXIETY PROVOKING CLIENTS ARE NOT LIKELY TO BE INCORPORATED IN THE TREATMENT PROCESS. THE TREATMENT PROCESS MAY THEREBY TEND TO DEFINE THE SUBJECTIVE LIVES OF ANXIETY PROVOKING CLIENTS AS IRRELEVENT IN CLINICAL DECISION MAKING.

THIS MUTUAL EXCLUSIVITY OF BEHAVIOR MODIFICATION AND PSYCHOTHERAPY MAY HAVE ITS FOUNDATIONS IN THE HISTORY OF BEHAVIOR MODIFICATION. BEHAVIOR MODIFICATION IS THE CLINICAL APPLICATION OF LABORATORY TECHNIQUES WHICH STRESSED CONTROLLED ENVIRONMENT. AS THE TECHNOLOGY BECAME AVAILABLE IN HOSPITAL AND SCHOOL SETTINGS, THE RESEARCH ORIENTATION FOLLOWED, AND DICTATED THAT UNCONTROLLED VARIABLES (PSYCHOTHERAPY) BE ELIMINATED FROM THE THERAPEUTIC DESIGN. THUS, IF ONE UTILIZED A BEHAVIOR MODIFICATION DESIGN, ONE WANTED TO DEMONSTRATE THAT IT WAS THE BEHAVIORAL TREATMENT THAT CREATED THE THERAPEUTIC CHANGE RATHER THAN ANY "UNCONTROLLED" VARIABLE. ALTHOUGH MANY CLINICAL APPLICATIONS OF BEHAVIOR MODIFICATION ARE NOT TIGHTLY CONTROLLED, THE PHILOSOPHY OF MUTUAL EXCLUSIVITY WITH PSYCHOTHERAPY APPEARS TO CONTINUE TO EXIST.

AT THE SAME TIME, THOSE WHO ADVOCATE THE USE OF PSYCHOTHERAPY TO THE EXCLUSION OF BEHAVIOR MODIFICATION MAY ALSO BE SUBJECT TO BIASES WHICH HAVE A HISTORICAL FOUNDATION. DURING THE EARLY YEARS OF BEHAVIOR MODIFICATION, THE PREDOMINATE FORM OF PSYCHOTHERAPY WAS PSYCHOANALYSIS. PYSCHOANALYSIS IS A RELATIVELY COMPLEX SYSTEM OF THERAPY WHICH REQUIRES INSIGHT AND GOOD VERBAL ABILITIES ON THE PART OF THE CLIENT. THIS IS IN MARKED CONTRAST WITH BEHAVIOR MODIFICATION, WHICH FOCUSES ON OVERT BEHAVIOR. THESE DIFFERENT PHILOSOPHIES OF TREATMENT MAY ALSO HAVE GENERATED A SENSE OF MUTUAL EXCLUIVENESS WHICH CONTINUES DESPITE THE EMERGENCE OF OTHER THERAPEUTIC APPROACHES.

WORKING WITH THE MENTALLY RETARDED WITH EMOTIONAL DIFFICULTIES IS AN EXTREMELY DIFFICULT TASK. IT APPEARS RATHER FOOLISH TO EXCLUDE POSSIBLE BENEFICIAL TREATMENT MODALITIES BASED ON OUTDATED NOTIONS AND ARGUMENTS. THE CURRENT TREATMENT LITERATURE INDICATES A MERGING OF THE BEHAVIORAL AND INSIGHT ORIENTED THERAPIST (COGNITIVE BEHAVIOR MODIFICATION, RATIONAL EMOTIVE THERAPY, TRANSACTIONAL ANALYSIS). HOWEVER, THESE THERAPEUTIC INTERVENTIONS CAN OFFER PROMISE TO THE EMOTIONALLY DISTURBED/MENTALLY RETARDED INDIVIDUAL ONLY IF THE THERAPIST'S DEGREEE OF DISCOMFORT IN WORKING WITH THESE PEOPLE CAN BE ALTERED.

+ + +